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**Issue Date: 21 April 2006**

Case No. 2003-BLA-6651

In the Matter of

JOSEPH A. AGNITSCH
Claimant

v.

FREEMAN UNITED COAL COMPANY
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party-in-Interest

Joseph A. Agnitsch, Pro Se
For the Claimant

John J. Scharkey, Esq.
For the Employer

Before: STEPHEN L. PURCELL
Administrative Law Judge

DECISION AND ORDER—DENYING BENEFITS

This case arises from a claim for benefits under the "Black Lung Benefits Act," Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. § 901 *et seq*. (hereinafter referred to as "the Act"), and applicable federal regulations, mainly 20 C.F.R. Parts 412, 718, and 727 ("Regulations").

Benefits under the Act are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis or to the survivors of persons whose death was

caused by pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as black lung.[1]

At a formal hearing held in Carbondale, Illinois on April 13, 2005, all parties presented evidence and argument, as provided in the Act and Regulations issued thereunder, found in Title 20, Code of Federal Regulations. Director's exhibits 1-29, Employer's exhibits 1-9, and Claimant's exhibits 1-4 were admitted into evidence at the hearing. (Tr. 10; 11-15; 67). Claimant's exhibit one is a copy of the Black Lung Benefits Act Evidence Summary Form initially submitted by Employer; however, Claimant's note on the Form states that the Department of Labor Exam and Dr. Tuteur's exam are what he is admitting into evidence. Accordingly, the contents of those two exams will also be designated as CX 1. Claimant's exhibits 2, 3, and 4 were admitted over Employer's objections. Specifically, Employer objected to Claimant's exhibits 2 and 3 on the basis that they are not relevant to this case, and objected to Claimant's exhibit 4, which is a newspaper article, on the basis that it is unable to cross-examine the author of the article. (Tr. 14, 67). I overruled Employer's objections at the hearing. *Id.* At the hearing, I requested that the parties submit their written closing arguments within thirty days following their receipt of the hearing transcript. Neither party submitted written briefs; therefore, I closed the record by Order dated August 3, 2005.

On August 9, 2005, counsel for Employer wrote that John Scharkey, Employer's representative at the hearing, inadvertently failed to forward a copy of the hearing transcript to Claimant, who is pro se, as instructed at the hearing. Employer's counsel advised that a copy of the transcript was sent to Claimant and asked that the record be reopened and the parties be given until September 9, 2005 to file written argument. By Order dated August 12, 2005, I reopened the record for the submission of written closing arguments, to be submitted by the parties on or before September 9, 2005. Employer's written argument was received September 9, 2005. No written argument was submitted by Claimant. Accordingly, the record is now closed.

## ISSUES

The contested issues are:

1. Whether Claimant has pneumoconiosis;

2. Whether the pneumoconiosis, if shown, arose out of Claimant's coal mine employment;

3. Whether the miner is totally disabled due to pneumoconiosis; and

4. Whether Claimant has established a change in condition pursuant to § 725.309(d).

(DX 28; Tr. 8-9).

[1] The following abbreviations have been used in this decision: DX = Director's exhibit; EX = Employer's exhibit; CX = Claimant's exhibit; Tr. = Transcript of the hearing; BCR = Board-certified radiologist; and B = B reader of x-rays.

## FINDINGS OF FACT AND CONCLUSIONS OF LAW

### Procedural History and Factual Background[2]

#### Procedural History

Claimant, Joseph A. Agnitsch, filed this second claim for benefits on June 5, 2002.[3] (DX 3) The District Director denied benefits by Proposed Decision and Order on March 10, 2003. (DX 21) The claimant disagreed with the determination and requested a formal hearing on July 21, 2003, and the case was forwarded to the Office of Administrative Law Judges on September 15, 2003, for hearing. (DX 24, 28) A hearing was originally held on September 29, 2004, in Carbondale, Illinois; however, the transcript of that hearing was lost by the court reporter. Consequently, Claimant chose to have a rehearing in order for his testimony to be considered as a part of the record. Tr. 5-6. The rehearing was held on April 13, 2005, in Carbondale, Illinois.

The findings of fact and conclusions of law that follow are based upon my analysis of the entire record, including all documentary evidence admitted, arguments made, and the testimony presented. Where pertinent, I have made credibility determinations concerning the evidence.

#### Background

At the hearing, Claimant testified he began working in the coal mines as a rock duster in 1946, following his military service. Tr. 16. Claimant explained that the work entailed running 600 to 700 pound sacks through a machine and that it was so dusty he couldn't see. Tr. 17. He stated that during this period, miners did not have respirators. *Id.* Claimant testified that he first worked for CW & F Coal Company for ten years, then worked as a welder at the Norge Washer Plant for eight years, and started at Freeman United Coal Company in 1963, working there until retirement in 1985. Tr. 18. He testified that all of his work for Freeman was underground and that he worked primarily as a roof bolter, but also as a beltman, and operated a continuous miner. Tr. 19-20. Claimant testified that he initially saw Dr. McCutchen for breathing difficulties in the 1970s and has seen Dr. Sanjabi consistently since he retired, approximately every two months. Tr. 22-23. Claimant testified that his daughter-in-law, Kimberly Agnitsch, is a certified respiratory therapist, and he has been under her care for the last four or five years or the last year and a half. Tr. 24, 32. He explained that she works at Herrin Hospital but treats him at home. Tr. 33.

Claimant testified that he has the most difficulties in the winter and that he uses a nebulizer every six hours. *Id.* Claimant stated that he also uses Advair and takes mucous pills. Tr. 25. He testified that he sees Dr. Julie Atkins when he has problems and that she admitted him to the hospital where he was put on oxygen and told by his daughter in law that the tests showed that he was "twenty percent shy of oxygen " in his blood. Tr. 26-27. Claimant stated

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[2] Given the filing date of this claim, subsequent to the effective date of the permanent criteria of Part 718 (i.e., March 31, 1980), the regulations set forth at 20 C.F.R. Part 718 will govern its adjudication. Because the miner's last exposure to coal mine dust occurred in Illinois, this claim arises under the jurisdiction of the U.S. Court of Appeals for the Seventh Circuit. *See Broyles v. Director, OWCP*, 143 F.3d 1348, 21 BLR 2-369 (10th Cir. 1998).

[3] Claimant's first claim for benefits, dated May 7, 1985, was denied on August 20, 1985. (DX 1)

that he was admitted to the hospital again with a high fever and erratic breathing. Tr. 28. Claimant testified that he subsequently had a Department of Labor black lung exam and was told he had black lung. Tr. 29. He stated that he went for a black lung exam with Employer's physician and that the physician told him he was breathing incorrectly, and that he pushed him too hard on the exercise test. Tr. 30.

Claimant testified that he quit smoking 60 years prior and last smoked at age nineteen or twenty. Tr. 35. He stated that he smoked about three unfiltered Lucky Strikes per day for about two years. Tr. 36. Claimant admitted that his answer to Employer's interrogatory question was that he had not ever smoked. Tr. 37-38. Claimant testified that the dust is so fine that one can't see it and that it takes eight hours for it to filter from the mine ceiling to the floor. Tr. 58. He stated that when he was a miner for CW & F Coal Company, at night he would cough and spit into a paper bag, and the sputum was as black as the coal. *Id*.

Claimant testified that he can't walk up a flight of stairs without getting short of breath, he can't mow his yard, pick up a five gallon bucket of water, or be around cigarette smoke. Tr. 61.

At the hearing, Employer called James Robert Hess as its witness. Mr. Hess testified he has been a coal miner all his life, worked as an underground union miner for five years, and started working for Freeman United Coal Company in March 1977. Tr. 40. Mr. Hess explained that at Freeman he worked as a bottom laborer, a position that fills all vacancies. Tr. 41. He testified that he worked as a rock duster and roof bolter at Freeman and became an underground section foreman until 1982, when he was promoted to assistant shift mine manager. *Id.* Mr. Hess explained that a rock duster's job entails spraying the mine walls and roof with powdered ground limestone to prevent combustion in the mines. Tr. 42. He testified that the process does not normally generate any additional dust and that the dust generated is rock dust as opposed to coal dust. Tr. 43. Mr. Hess stated that at Freeman, everyone that rock dusted wore respirators. *Id.* Mr. Hess described the process of roof bolting and stated that dust generated from drilling a hole in the mine roof went into a filtered collecting tank on the machine. Tr. 45. He explained that the process is similar to a vacuum cleaner but that the dust tanks are made out of steel with drop doors on the bottom to empty them. *Id.* Mr. Hess testified that the only time extensive dust was created was when a miner did not empty his dust tanks or if he was using an auger instead of the vacuum stem. Tr. 46.

Mr. Hess explained how conveyer belting works and testified that this process will create dust if the belts are allowed to spill and the spillage is not cleaned up. Tr. 47-48. He stated that spillage occurred when the belts are misaligned. Tr. 48. Mr. Hess testified that coal dust problems at the conveyer belt became less common in later years because miners used water to suppress coal dust. Tr. 49. Mr. Hess explained how the continuous miner worked at Freeman and testified that it creates coal dust by scraping the coal face. Tr. 50-51. He stated that mining laws require miners to use at least 9,000 cubic feet of air a minute while working at the face, either by using a curtain or using an exhaust fan. Tr. 51. He stated that beginning in 1978, the machines had a dust collector component to them. *Id.* Mr. Hess testified that if everything were working properly, the continuous miner would not have generated enough dust to prevent a miner from seeing in front of his face. Tr. 52.

Duplicate Claim

The current claim was filed more than one year after the denial of Claimant's last claim for benefits. As such, the new evidence submitted in connection with the subsequent claim must establish a change in at least one condition of entitlement previously adjudicated against Claimant. 20 C.F.R. § 725.309(d) (2001). If a change in condition is established, a *de novo* review of the record will be conducted to determine if Claimant is entitled to benefits. *See also Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994). To prevail on the new claim, therefore, the miner must show that something capable of making a difference has changed since the record closed on the first application. *Peabody Coal Co. v. Spese*, 117 F.3d 1001, 1008 (7th Cir. 1997). Claimant's previous claim was denied because the evidence did not establish that he suffers from pneumoconiosis or that he is totally disabled due to pneumoconiosis. (DX 1) As is discussed in detail below, the recent evidence establishes that the claimant now suffers from pneumoconiosis. This constitutes a change in an applicable condition of entitlement pursuant to 20 C.F.R. § 725.309(d) (2001). Therefore, I have considered all of the evidence in the record in reaching my decision.

Medical Evidence[4]

Chest x-rays

The record contains the following chest x-ray evidence:

| Exhibit No. | Date x-ray | Physician/Qualifications | Interpretation |
|---|---|---|---|
| DX 1 | 6/25/85 | Martin (illegible) | 2/2, t/q. Film quality 1. |
| DX 1 | 6/25/85 | Pitman/BCR, B | Completely negative. Film quality 1. |
| EX 1 | 3/6/97 | Scott/BCR, B | Film quality 2—high contrast copies. No parenchymal or pleural abnormalities consistent with pneumoconiosis. Hyperinflation lungs; deep breath versus emphysema. Healed fracture 9th rib. |
| DX 22 | 12/25/98 | Najem | No acute process. Hyperinflation of the lungs compatible with probable chronic |

[4] The employer's exhibit numbers 1-5 for the chest x-rays are mis-labeled. Specifically, the exhibit numbers written on the actual chest x-ray exhibits differ from the designations on the employer's Black Lung Benefits Act Evidence Summary Form. Accordingly, I designated the x-rays above with the numbers printed on the actual exhibits, as opposed to what is listed in the Summary Form.

| | | | |
|---|---|---|---|
| | | | obstructive pulmonary disease. Pulmonary vascular prominence. |
| EX 4 | 12/25/98 | Scott/BCR, B | Film quality 2—high contrast copies. No parenchymal or pleural abnormalities consistent with pneumoconiosis. Hyperinflation lungs; deep breath versus emphysema. Healed fracture 9th rib. |
| DX 22 | 4/2/02 | Meeks | Mild chronic obstructive pulmonary disease. No evidence of acute cardiopulmonary lesion. |
| EX 5 | 4/2/02 | Scott/BCR, B | Film quality 3—high contrast copies. No parenchymal or pleural abnormalities consistent with pneumoconiosis. Scapula over lungs. Hyperinflation lungs; deep breath versus emphysema. Healed fracture 9th rib. |
| EX 2 | 8/8/02 | Scott/BCR, B | Film quality 2—dark copies. No parenchymal or pleural abnormalities consistent with pneumoconiosis. Hyperinflation lungs; deep breath versus emphysema. Healed fracture 9th rib. |
| DX 14, CX1 | 8/29/02 | Main/B | Film quality 1. 1/0, p/p. No pleural abnormalities consistent with pneumoconiosis. |
| EX 3 | 8/29/02 | Scott/BCR, B | Film quality 2— underexposure PA. Completely negative. |
| DX 15 | 8/29/02 | Gaziano/B (Read for quality only) | Film quality (illegible) "cut off." |
| CX 1 | 12/12/03 | Tuteur/B[5] | 1/0. Cardiac silhouette |

[5] This chest x-ray report is part of Dr. Tuteur's examination of the miner which also appears in the record as Employer's Exhibit 6. However, this x-ray was not and cannot be designated as part of Employer's exhibit because it would exceed the evidentiary limitations set forth at 20 C.F.R. § 725.414 (2001).

borderline. Lung volumes normal. Trivial increase in nodular density seen predominantly in upper lung fields and periphery.

Pulmonary Function Studies

The record contains the following pulmonary function study evidence:

| Ex. No. | Date | Age | Height | FEV1 | MVV | FVC | FEV1/FVC% | Qualify? |
|---|---|---|---|---|---|---|---|---|
| DX 1 | 6-25-85 | 61 | 68" | 3.21 | 124 | 4.70 | ___ | No. |
| Cooperation and comprehension good. | | | | | | | | |
| EX 7 | 3-25-97 | | | 3.69 | __ | 4.62 | 79.8% | No. |
| Cooperation and comprehension not noted. | | | | | | | | |
| DX 13 | 8-29-02 | 79 | 66" | 2.56 | __ | 3.83 | 67% | No. |
| Good cooperation and comprehension. Mild small airway obstruction. | | | | | | | | |
| EX 6 | 12-12-03 | | | 2.62 | __ | 3.90 | 67% | No. |
| | | | | *2.94 | | *4.15 | *71% | No. |
| Good patient effort noted. | | | | | | | | |

* = Post-Bronchodilator

Arterial Blood Gas Studies

The record contains the following arterial blood gas study evidence:

| Ex. No. | Date | pO2 | PCO2 | Qualify? |
|---|---|---|---|---|
| DX 1 | 7-8-85 | 90 | 31 | No. |
| | | *108 | *26 | No. |
| DX 12, EX 8 | 8-29-02 | 89 | 35 | No. |
| | | *111 | *25 | No. |
| Comments: Excellent exercise effort. ABG normal before and after exercise. | | | | |
| EX 6 | 12/12/03 | 80 | 34.8 | No. |
| *111 | | *102 | *32.2 | No. |
| Comments: Good patient effort. | | | | |

* = Post-Exercise

Medical Reports

Hospitalization Records and Treatment Notes

The record contains the miner's hospitalization and treatment records from Memorial Hospital of Carbondale for an admission on December 25, 1998. (DX 22) The records reveal that Claimant presented to the ER with complaints of a harsh cough, fever of 101 to 102 degrees, and shortness of breath of three to four days duration. The report states that the process began with sinus congestion that progressed to the lungs. Claimant reported breathing problems since leaving the coal mines and using an inhaler twice per day. He reported being fairly active but has some exertional limitation due to shortness of breath and reported doing reasonably well other than this attack. The record notes Claimant's 31-year coal mine employment history, with 22 years underground, and notes that he quit smoking 50 years prior. A chest x-ray taken in the ER was reported as revealing increased bronchial markings, Claimant's PO2 was reported as 62, otherwise the gases are normal, and the PCO2 is normal. The physical exam report is essentially normal and notes that a chest x-ray reveals hyperinflated lung, increased markings in the right lower lobe region, and a question of right lower lobe pneumonitis. The report notes that the cardiac silhouette appears normal. The assessment is a "seventy-five year old white male presenting with a history of fever, cough, shortness of breath, bronchospasm with x-ray suggestive of rll."

The record contains patient progress notes from the Southern Illinois Respiratory Disease Program dated December 12, 2002 and June 18, 2002. (DX 22) The first progress note is essentially illegible but indicates the miner is a retired coal miner of 31 years, questions CWP and COPD, notes that Claimant has not done a pulmonary function test, takes his meds, and had no rhonchi. The second progress note reveals that Claimant did not take a pulmonary function test because he applied for black lung benefits; Claimant reported that his meds are helping and he feels better, and he was advised to continue his meds until he takes the pulmonary function test.

The record contains a note from Franklin Community Care Services, Inc. dated May 28, 2002 that reveal that the Claimant reported more dyspnea progressively, no cough or sputum, no PND, no known heart problem. The report notes a prolonged ejection fraction, no J.V.D., (illegible), no edema, no cyanosis or clubbing. (DX 22)

*Dr. Y.N. Chiou*

Dr. Chiou examined Claimant on behalf of the Department of Labor in connection with his first claim for benefits on July 8, 1985. (DX 1) His credentials are not in the record. Dr. Chiou recorded a coal mine employment history as a rock duster and trip rider, ranging from 1947 to 1955 and again from 1963-present (1985). He noted that the miner also worked as a welder from 1955 to 1963. Dr. Chiou recorded a negative family history and recorded the miner's individual history as positive for attacks of wheezing. He noted that the miner smoked six cigarettes per day for two years and stopped smoking in 1961. Dr. Chiou recorded the miner's chief complaints as cough, sputum, and wheezing. The miner's physical exam was

essentially normal but Dr. Chiou noted "chest expansion 1 ½ inches, diaphragm expansion > 3 cm, and mild varicosity."

Dr. Chiou noted that the miner could walk five to six blocks, climb ten flights of stairs, lift 100 pounds and carry it 100 feet. Dr. Chiou's diagnosis was "normal physical exam on CP system."

*Dr. David M. Main*

Dr. Main examined the miner on behalf of the Department of Labor on August 29, 2002 and completed Form CM 988 and a typed report. His report appears in the record at DX 11. Dr. Main is board certified in internal medicine, pulmonary disease, and preventive occupational medicine and is a B reader. (EX 6) Dr. Main recorded a coal mine employment history as a rock duster and roof bolter from 1946 to 1955, and from 1963 to 1985, and employment as a welder at Norge Washer Plant from 1956-1963. Dr. Main noted that the miner's family history is positive for emphysema in his father, and recorded the miner's medical history as positive for attacks of wheezing beginning in 1985 and chronic bronchitis that is intermittent since 1985. He noted that the miner was hospitalized for a urinary tract infection with sepsis.

Dr. Main recorded a cigarette smoking history from 1945 to 1950 consistent with 1/3 pack per day. He recorded the miner's present illness as coughing a teaspoon of sputum daily, dyspnea after walking two to three blocks or less than a flight of stairs, and daily cough "for years" or the last ten to twenty years. He noted that the miner reported frequent nasal drainage. Dr. Main recorded the miner's medicines as Allegra, Synthroid, and Albuterol nebulizer. The miner's physical exam was essentially normal and the chest was clear to auscultation. Dr. Main performed objective tests consisting of a chest x-ray that he noted to reveal small micronodular densities consistent with CWP, and pulmonary function study revealing small airways obstruction, and an arterial blood gas study that was normal.

Dr. Main's cardiopulmonary diagnosis was mild CWP on the basis of the chest x-ray and exposure to coal. He recorded the impairment as "mild on basis of mild profusion of 'p' nodules on chest x-ray and minimal abnormality on PFT."

*Dr. Peter G. Tuteur*

Dr. Tuteur, who is board certified in internal medicine and pulmonary disease and is a B reader, examined the miner on December 12, 2003. His report appears in the record at CX 1 and EX 6. Dr. Tuteur recorded a coal mine employment history as a rock duster, driller, trip rider, and roof bolter from 1946-1985, and noted that he smoked cigarettes only briefly. He noted that the miner retired at age 62 due to shortness of breath. He noted that Claimant was exposed to sufficient amounts of coal mine dust to produce coal workers' pneumoconiosis in a susceptible host. Dr. Tuteur noted that Claimant is unable to walk more than 100 yards or climb half a flight of stairs before stopping, experiences paroxysmal nocturnal dyspnea, morning cough with sputum, and occasional wheezing that is relieved by nebulizer treatment.

Dr. Tuteur recorded that the miner's father had black lung disease. The miner's physical exam was essentially normal. Examination of the chest revealed full, equal, and synchronous expansion and normal breath sounds. He noted that on deep forceful inspiration, late inspiratory crackles are heard in most lung fields, predominantly in the upper lung fields both anteriorly and posteriorly. A chest x-ray was performed which revealed a trivial increase in the nodular density seen predominantly in the upper lung fields and the periphery, with ILO classification of 1/0. Dr. Tuteur reviewed the miner's CT scan and stated that it is abnormal because of peripheral nodular densities of minimal profusion in the upper lung fields associated with a few sub-centimeter nodules that are either fully calcified or indeterminate. He noted that there is no emphysema and the nodular densities are consistent with what is seen in very early simple coal workers' pneumoconiosis.

Dr. Tuteur stated that pulmonary function studies demonstrate normal spirometry without clear and significant improvement following bronchodilator, normal lung volumes and diffusing capacity. He noted that there is no impairment in gas exchange at rest nor during exercise and carboxyhemoglobin level is consistent with nonsmoking status. Dr. Tuteur opined that Claimant has some degree of exercise intolerance associated with paroxysmal nocturnal dyspnea potentially aggravated by sinusitis and he has CT demonstrable early simple coal workers' pneumoconiosis associated with standard chest radiograph classified as ILO 1/0. He explained that this finding is associated with late inspiratory crackles, yet the miner's coal workers' pneumoconiosis is of insufficient severity and profusion to produce clinical symptoms or physiologic abnormalities. Dr. Tuteur stated that the reason for Claimant's shortness of breath is not identified in this evaluation and one must consider cardiac dysfunction.

*Dr. Lawrence H. Repsher*

Dr. Repsher reviewed the miner's medical records and issued a report dated January 26, 2004, which appears in the record at EX 9. Dr. Repsher is board certified in internal medicine, pulmonary disease, critical care medicine, and is a B reader. Dr.
Repsher noted that Claimant worked approximately 31 years as a rock duster, trip rider, and roof bolter in the coal mines. He recorded the miner's cigarette smoking history as six cigarettes per day for two years, ending in 1961. Dr. Repsher recorded the miner's family and individual medical histories as positive for emphysema and black lung in his father, and noted that the miner suffers from hypothyroidism, hyperlipidemia, intermittent bouts of acute purulent bronchitis with bronchospasm, and urosepsis (E. coli).

Dr. Repsher disagreed with Dr. Main's diagnosis of mild small airways obstruction and stated that spirometry and arterial blood gases were well within normal limits and there was no evidence of pulmonary impairment. Dr. Repsher opined that Claimant might have mild simple coal workers' pneumoconiosis. He explained that the reasons for this opinion are: 1) There is some evidence to suggest simple coal workers' pneumoconiosis; 2) There is chest CT scan evidence to support the diagnosis of simple coal workers' pneumoconiosis; 3) Claimant has normal pulmonary function tests; 4) He has no arterial blood gas evidence of coal workers' pneumoconiosis, his most recent tests are normal and this would rule out any clinically significant interstitial lung disease, such as coal workers' pneumoconiosis; 5) Claimant has other

medical conditions; however, none of these conditions can be fairly attributed to his work as a coal miner with the inhalation of coal dust.

Dr. Repsher opined that there is some objective evidence to justify the diagnosis of coal workers' pneumoconiosis, the miner has no respiratory impairment that has arisen from his coal mining employment with the inhalation of coal dust, and he retains the respiratory capacity to perform the work of an underground coal miner or any other work requiring a similar degree of physical labor. Dr. Repsher stated, with a reasonable degree of medical certainty, that Claimant has no evidence of a disabling respiratory or pulmonary impairment related to his coal mine dust exposure, either in whole or in part.

CT Scan Evidence

Claimant underwent a CT scan on December 12, 2003. It was interpreted by Dr. David Gierada and appears in the record at EX 6. Dr. Gierada's impression was: 1) Multiple small noncalcified nodules in a distribution compatible with silicosis or coal workers' pneumoconiosis. Sarcoid and metastatic disease also could be considered if clinically appropriate; 2) No pulmonary fibrosis; 3) Numerous indeterminate pulmonary nodules throughout the lungs bilaterally with the largest measuring 5 mm in diameter. CT follow-up is recommended in six to twelve months to evaluate for growth of these largest nodules, for any evidence of growth that would suggest neoplasm; 4) Cholelithiasis with no indication of cholecystitis; 5) Coronary artery disease. Addendum: There is also a six mm opacity in the right upper lobe apical segment that may represent a confluence of vessels, a lung nodule, or a peribronchial lymph node. Attention to this on a follow-up CT is recommended.

Non-Medical Supporting Evidence

Claimant submitted two letters in support of his claim that appear in the record as CX 2 and 3. The first letter is from the miner's wife, Anna Agnitsch. (CX 3) Mrs. Agnitsch wrote that Claimant's condition worsened over time and he has difficulty walking up stairs. She stated that he can no longer enjoy the outdoors and hunt and fish. Mrs. Agnitsch wrote that Claimant must be supervised when he goes out and that he coughs up mucous when walking from the dining room to the kitchen. She stated that he is on a nebulizer every six hours and that his active life has come to a halt.

Claimant's second letter is from his daughters, Brenda Boner and Melissa Barkley. (CX 2) They describe their difficulty in watching their father struggle to breathe and state, "he can no longer walk from one to another with [sic] stopping in between." Claimant's daughters note that he can no longer go to his grandchildren's games and either stays home or rides with their mother. They wrote that two years prior, at Christmas dinner, Claimant had a breathing episode and was admitted to the hospital for low oxygen level in his blood.

Claimant submitted an article from "The Daily American" newspaper, dated April 1, 2005. It appears in the record at CX 4. The article recounts the 1951 disaster at the Chicago, Wilmington and Franklin Coal Company's New Orient Mine No. 2, which killed 119 men.

## Conclusions of Law

### Length of Coal Mine Employment

The parties stipulated and I find that Claimant was a coal miner within the meaning of the Act for 31 years. Tr. 9.

### Date of Filing

I find that Claimant filed his claim for benefits under the Act on June 5, 2002. (DX 3)

### Responsible Operator

Employer has not contested that it is the Responsible Operator. Accordingly, I find that Freeman United Coal Company is the responsible operator and will provide payment of any benefits awarded to Claimant.

### Dependents

I find that Claimant has one dependent, his wife, Anna, for purposes of augmentation of benefits under the Act. (DX 1)

## Standard of Review

The administrative law judge need not accept the opinion of any particular medical witness or expert, but must weigh all the evidence and draw his/her own conclusions and inferences. *Lafferty v. Cannelton Industries, Inc.*, 12 B.L.R. 1-190 (1989); *Stark v. Director, OWCP*, 9 B.L.R. 1-36 (1986); *Todd Shipyards Corp. v. Donovan*, 300 F.2d 741 (5th Cir. 1962). The adjudicator's function is to resolve the conflicts in the medical evidence; those findings will not be disturbed on appeal if supported by substantial evidence. *Lafferty, supra*; *Fagg v. Amax Coal Co.*, 12 B.L.R. 1-77 (1988); *aff'd*, 865 F.2d 916 (7th Cir. 1989); *Short v. Westmoreland Coal Co.*, 10 B.L.R. 1-127 (1987); *Piccin v. Director, OWCP*, 6 B.L.R. 1-616 (1983); *Peabody Coal Co. v. Lowis*, 708 F.2d 266, 5 B.L.R. 2-84 (7th Cir. 1983).

In considering the medical evidence of record, an administrative law judge must not selectively analyze the evidence. *See Wright v. Director, OWCP*, 7 B.L.R. 1-475 (1984); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295 (1984); *Crider v. Dean Jones Coal Co.*, 6 B.L.R. 1-606 (1983); *Peabody Coal Co. v. Lowis*, 708 F.2d 266, 5 B.L.R. 2-84 (7th Cir. 1983); *see also Stevenson v. Windsor Power House Coal Co.*, 6 B.L.R. 1-1315 (1984). The weight of the evidence, and determinations concerning credibility of medical experts and witnesses, however, is for the administrative law judge to determine. *Mabe v. Bishop Coal Co.*, 9 B.L.R. 1-67 (1986); *Brown v. Director, OWCP*, 7 B.L.R. 1-730 (1985); *see also Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985); *Henning v. Peabody Coal Co.*, 7 B.L.R. 1-753 (1985); *Peabody Coal Co. v. Benefits Review Board*, 560 F.2d 797, 1 B.L.R. 2-133 (7th Cir. 1977).

As the trier-of fact, the administrative law judge has broad discretion to assess the evidence of record and determine whether a party has met its burden of proof. *Kuchwara v. Director, OWCP*, 7 B.L.R. 1-167 (1984). In considering the evidence on any particular issue, the administrative law judge must be cognizant of which party bears the burden of proof. Claimant has the general burden of establishing entitlement and the initial burden of going forward with the evidence. *See White v. Director, OWCP*, 6 B.L.R. 1-368 (1983).

The Existence of Pneumoconiosis

Pneumoconiosis is defined as a "chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." 30 U.S.C. § 902(b) and 20 C.F.R. § 718.201. The definition is not restricted to coal workers' pneumoconiosis but also includes other diseases arising out of coal mine employment, such as anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis, or silicotuberculosis. 20 C.F.R. § 718.201. The term "arising out of coal mine employment" is defined as including "any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment. *Id.* Thus, "pneumoconiosis", as defined by the Act, has a much broader legal meaning than does the medical definition.

The claimant has the burden of proving the existence of pneumoconiosis by any one of four methods: (1) a chest x-ray meeting the criteria set forth in 20 C.F.R. § 718.202(a); (2) a biopsy or autopsy conducted and reported in compliance with 20 C.F.R. § 718.106; (3) application of the irrebuttable presumption for "complicated pneumoconiosis" found in 20 C.F.R. § 718.304; or (4) a determination of the existence of pneumoconiosis made by a physician exercising sound judgment, based upon certain clinical data and medical and work histories, and supported by reasoned medical opinion. 20 C.F.R. § 718.202(a). In addition, other medically acceptable tests or procedures not described in the Act that may tend to establish the presence or absence of pneumoconiosis may be considered. 20 C.F.R. § 718.107.

Chest X-ray Evidence

A finding of the existence of pneumoconiosis may be made with positive chest x-ray evidence. 20 C.F.R. § 718.202(a)(1). The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. A chest x-ray classified as category 0, including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b). Because pneumoconiosis is a progressive and irreversible disease, it may be appropriate to accord greater weight to the most recent evidence of record. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989)(en banc); *Casella v. Kaiser Steel Corp.*, 9 B.L.R. 1-131 (1986).

Where two or more x-ray reports are in conflict, the radiographic qualifications of the physicians interpreting the x-rays must be considered. 20 C.F.R. § 718.201(a)(1). The interpretations of physicians who are dually-qualified (board-certified radiologists and B-readers) are entitled to the greatest weight. The Benefits Review Board held that it is proper to

credit the interpretation of a dually-qualified physician over the interpretation of a B-reader. *Cranor v. Peabody Coal Co.*, 22 B.L.R. 1-1 (1999)(en banc on recon.).

Of the submitted evidence, there are eleven interpretations of seven chest x-rays. Of these eleven interpretations, three were read as positive for coal workers' pneumoconiosis by two B readers and a physician whose credentials are unknown. Two other x-rays diagnosed probable chronic obstructive pulmonary disease;[6] however, these x-rays were taken during the course of the miner's hospitalizations and were not read for the purpose of determining whether the miner has pneumoconiosis.[7] Moreover, neither of these x-rays addresses the ILO criteria and neither party has designated the readings as part of its affirmative evidence. Accordingly, I find that these chest x-rays are entitled to less weight.

There were six negative interpretations all of which were made by dually-qualified physicians. Two of the negative interpretations were submitted by Employer to rebut the two non-ILO hospital x-rays. As I determined that the hospital x-rays are entitled to less weight and are not a part of Claimant's designated affirmative evidence, I find that Employer's rebuttal interpretations are unduly repetitious and are also entitled to less weight.

Of the remaining six chest x-rays, there are three positive interpretations and four negative interpretations. The first positive chest x-ray was taken in 1985, interpreted by a physician with unknown credentials, and numerous subsequent interpretations by dually-qualified physicians were negative. Since pneumoconiosis is recognized as a latent and progressive disease, I find this positive interpretation is entitled to little weight. 20 C.F.R. § 718.201(c) (2001). The second positive chest x-ray, taken August 29, 2002, was interpreted by a B reader. This same x-ray was interpreted as negative by a dually-qualified physician. In addition, an x-ray taken immediately before it, on August 8, 2002, was also interpreted as negative by a dually-qualified physician. I find that the proximate negative interpretations by the dually-qualified physicians outweigh the positive interpretation by the B reader.

The third positive interpretation was the most recent x-ray, taken on December 12, 2003 and interpreted by a B-reader. The x-ray appears within Dr. Tuteur's report but is not contained on the standard ILO form. An x-ray interpretation need not be submitted on an official form, but may be contained in the body of a medical report. *Consolidation Coal Co. v. Chubb*, 741 F.2d 968 (7th Cir. 1984). However, the regulations provide that "no chest x-ray shall constitute evidence of the presence or absence of pneumoconiosis unless it is conducted and reported in accordance with the quality requirements of (§ 718.102) and Appendix A. 20 C.F.R. § 718.102(c)(2001).

Appendix A provides, in pertinent part, that each x-ray "shall be permanently and legibly marked with the name and address of the facility at which it is made (and) the miner's DOL claim number…"Although the x-ray film is not in the record, the x-ray report does not give the name and address of the facility at which it was taken, nor does it give Claimant's DOL claim number. Additionally, Dr. Tuteur's report does not indicate where the chest x-ray was taken.

[6] Chronic obstructive pulmonary disease falls under the definition of "legal pneumoconiosis" if it arises out of coal mine employment. 20 C.F.R. § 718.201 (2001).
[7] The x-rays were taken December 25, 1998 and April 2, 2002.

The only indication of the facility is "BJH". The report does not indicate the film quality, nor does it give the qualifications of the person taking the film or providing the initial interpretation in the original report, other than that the radiology attending physician reviewed the report. 20 C.F.R. § 718.102(c). Additionally, the initial report, as interpreted by the radiology attending physician, does not indicate that it was interpreted in compliance with § 718.102. Dr. Tuteur interpreted the x-ray as ILO classification 1/0. The x-ray report itself, however, states "there is a nodular opacity in the right suprahilar region, possibly representing a pulmonary nodule, such as from pulmonary neoplasm." Even relying solely on Dr. Tuteur's interpretation, there is no evidence that the chest x-ray meets the quality standards set forth in the regulations. Therefore, it cannot constitute evidence of the presence of pneumoconiosis.

Accordingly, as the majority of dually-qualified interpretations are negative for pneumoconiosis and the most recent interpretation does not meet the regulatory qualifications, I find that Claimant has not established, by the preponderance of the chest x-ray evidence, the existence of pneumoconiosis pursuant to 20 C.F.R. § 718.202(a)(1).

Biopsy Evidence

Pursuant to 20 C.F.R. § 718.202(a)(2), Claimant may establish pneumoconiosis through the use of biopsy evidence. Since no such evidence was submitted, pneumoconiosis is not established in this manner.

Complicated Pneumoconiosis

There is no evidence that the miner suffers from large opacity, complicated pneumoconiosis; therefore, he is not entitled to the irrebuttable presumption set forth at 20 C.F.R. § 718.304.

Medical Opinion and CT Scan Evidence

Medical reports that are based upon and supported by patient histories, a review of symptoms, and a physical examination, constitute adequately documented medical opinions as contemplated by the Regulations. *Justice v. Director, OWCP*, 6 B.L.R. 1-1127 (1984). However, where the physician's report, although documented, fails to explain how the documentation supports its conclusions, an administrative law judge may find the report is not a reasoned medical opinion. *Smith v. Eastern Associated Coal Co.*, 6 B.L.R. 1-1130 (1984). A medical opinion shall not be considered sufficiently reasoned if the underlying objective medical data contraindicates it. *White v. Director, OWCP*, 6 B.L.R. 1-368 (1983).

The reports of four physicians were submitted regarding Claimant's medical condition. All of the physicians reviewed the miner's medical records and all of the physicians but Dr. Repsher also examined the miner and performed objective tests. I find that all of their opinions are well-documented. Dr. Chiou's diagnosis was, "normal physical exam on CP system." As Dr. Chiou did not provide further information or relate any of the objective and physical findings to his diagnosis, I find that his report is not well reasoned and is entitled to little weight.

Dr. Main diagnosed mild coal workers' pneumoconiosis based on his interpretation of the miner's chest x-ray and his exposure to coal dust. Dr. Main based his opinion on the objective studies, and the miner's lengthy coal mine employment history. Although I subsequently determined that Dr. Main's positive chest x-ray interpretation was outweighed by the negative interpretation of a better-qualified physician, his opinion is entitled to some weight because he relied on additional factors in his diagnosis and it is well reasoned.

Dr. Tuteur opined that the miner has simple coal workers' pneumoconiosis based on the positive CT scan, the chest x-ray he classified as 1/0, the miner's physical examination findings of late inspiratory crackles, and his coal mine employment history. Of the medical opinions, Dr. Tuteur's is the best reasoned. He based his diagnosis not only on the objective studies and the CT scan, but also on the miner's physical examination findings.

Dr. Repsher opined that Claimant may have simple coal workers' pneumoconiosis and stated that there is some chest x-ray evidence to suggest simple coal workers' pneumoconiosis and there is chest CT scan evidence to support the diagnosis of simple coal workers' pneumoconiosis. Although Dr. Repsher did not personally examine Claimant, he relied on the extensive medical records, and his opinion is corroborated by the opinions of Drs. Tuteur and Main. Dr. Repsher's opinion, however, is equivocal in that he opined that Claimant "may" have simple coal workers' pneumoconiosis. Therefore, I find that Dr. Repsher's opinion is well-reasoned but entitled to less weight than Drs. Tuteur and Main's similar opinions because it is equivocal.

The CT scan of the chest revealed multiple small nodules in a distribution pattern consistent with silicosis or coal workers' pneumoconiosis. The interpreting radiologist also wrote that sarcoid or metastatic disease could be considered if that is clinically appropriate. I note, however, that none of the reviewing physicians or Claimant's other hospitalization and treatment records indicate that sarcoid disease or cancer was a consideration or an issue in his treatment.

Weighing the recent medical opinion evidence together, including the CT scan of the chest, I find that Claimant has established the presence of coal workers' pneumoconiosis pursuant to 20 C.F.R. § 718.202(a)(4). Dr. Chiou provided the medical opinion evidence in the miner's first claim. I previously found his opinion entitled to little weight and, in addition, because coal workers' pneumoconiosis is a latent and progressive disease, his opinion is not reflective of the miner's current condition. Therefore, after weighing the medical opinion evidence from the miner's first claim with the new opinion evidence, I find that Claimant has still established the presence of pneumoconiosis pursuant to the medical opinion evidence at § 718.202(a)(4).

I previously found that Claimant did not establish the existence of pneumoconiosis through the chest x-ray evidence and I found that he did establish the presence of pneumoconiosis with the medical opinion evidence at §718.202(a)(4). I also found that there is no biopsy evidence in the record and that the presumptions at § 718.202(a)(3) are inapplicable to this case. In addition, I noted that the CT scan evidence diagnosed silicosis or coal workers' pneumoconiosis. As the physicians rendering opinions took into consideration all of the medical

evidence in the record, including the recent chest CT scan and also Claimant's work and social histories, I find that the medical opinion evidence is more persuasive than the chest x-ray evidence. Accordingly, I find that the medical opinion evidence and the CT scan evidence outweigh the chest x-ray evidence and that Claimant has established the existence of pneumoconiosis pursuant to § 718.202(a).

Cause of Pneumoconiosis

Once it is determined that the miner suffers from pneumoconiosis, it must be determined whether the miner's pneumoconiosis arose, at least in part, out of coal mine employment. Twenty C.F.R. § 718.203(a)(2003) provides that if a miner who is suffering from pneumoconiosis was employed for ten or more years in the coal mines, there shall be a rebuttable presumption that the pneumoconiosis arose out of that coal mine employment.

I find that Claimant, with 31 years of coal mine employment, is entitled to the rebuttable presumption at § 718.203. Moreover, I note that Claimant's cigarette smoking history is negligible in relation to his coal mine employment history and there is no other evidence in the record or in the physician opinion reports that indicates that Claimant was exposed to anything other than the products of working in the coal mines. For these reasons, I find that Employer has not submitted any evidence to rebut this presumption and that Claimant's pneumoconiosis arose out of his coal mine employment.

Evidence of Total Disability and Disability Causation

Claimant' s previous claim was also denied because he failed to prove that he was totally disabled due to pneumoconiosis. Total disability is defined as pneumoconiosis that prevents or prevented a miner from performing his usual coal mine employment or other comparable gainful work. 20 C.F.R. §§ 718.305(c), 718.204(b)(1). A finding of total disability may be based on the criteria found in § 718.204(b)(1), which provides that a miner will be considered totally disabled if the irrebuttable presumption set forth in § 718.304 applies,[8] or may be established by the criteria set forth in § 718.204(b)(2), which consists of qualifying pulmonary function studies, qualifying blood gas studies, the existence of cor pulmonale with right sided congestive heart failure, and the opinion of a physician, exercising sound medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concluding that the miner's pulmonary condition prevents him from performing his usual coal mine work.

I previously found that Claimant is not entitled to the irrebuttable presumption set forth in § 718.304. In addition, there is no evidence that he suffers from cor pulmonale with right-sided congestive heart failure.

There are four pulmonary function studies in the record. As none of the studies are qualifying, I find that Claimant has failed to establish total disability pursuant to the pulmonary function study evidence at § 718.204(b)(2)(i)(2003).

[8] There is an irrebuttable presumption that a miner is totally disabled due to pneumoconiosis if a chest x-ray yields one or more large opacities (greater than 1 centimeter) and would be classified as Category A, B, or C as further specified in the Regulation.

There are three arterial blood gas studies in the record, none of which are qualifying. Accordingly, I find that Claimant has not established total disability pursuant to § 718.204(b)(ii)(2).

There are four physicians who rendered opinions relative to this issue. Dr. Chiou did not address whether the miner is totally disabled but stated that the miner's physical examination was normal. As he did not address the issue, his opinion is entitled to no weight.

Dr. Main opined that the miner has a mild impairment based on his chest x-ray and minimal abnormality on the pulmonary function test. Dr. Main did not, however, discuss what, if any, impact the impairment would have on Claimant's ability to perform his previous coal mine work or a similar job. Since Dr. Main did not discuss Claimant's impairment in relation to his coal mine employment, his opinion is entitled to little weight.

Dr. Tuteur opined that Claimant has some degree of exercise intolerance but opined that his coal workers' pneumoconiosis is of insufficient severity and profusion to produce clinical symptoms or physiologic abnormalities. Dr. Tuteur also did not discuss whether this exercise intolerance would prevent Claimant from performing his previous coal mine employment or similar work. Therefore, his opinion is entitled to little weight.

Dr. Repsher opined that Claimant has no respiratory impairment based on his physical examination reports and non-qualifying objective studies. He stated that Claimant retains the respiratory capacity to perform the work of an underground coal miner or any other work requiring a similar degree of physical labor. As Dr. Repsher related Claimant's physical and objective examination results to his coal mine employment requirements, I find that his opinion is entitled to greater weight on this issue.

In weighing the physician's opinions, I note that all of them appear sufficiently well-documented, in that all of them are based on both objective tests and the miner's physical complaints. All of the physicians were aware of the exertional requirements of the miner's previous coal mine work. However, I find the opinion of Dr. Repsher to be more persuasive, as he is the only physician to relate the miner's pulmonary capabilities to his coal mine employment. Based on the above, weighing the physician opinion reports together, I find that Claimant has not established, by a preponderance of the medical opinion evidence, that he is totally disabled from performing his previous coal mine work or comparable work pursuant to 20 C.F.R. § 718.204(b)(2)(iv)(2003).

Although the record includes letters from Claimant's wife and daughters that discuss his breathing difficulties and daily activities, in a living miner's claim, lay testimony cannot support the finding of a totally disabling respiratory impairment in the absence of corroborating medical evidence. *Madden v. Gopher Mining Co.*, 12 B.L.R. 1-122 (1999); *Milburn v. Colliery Co. v. Director, OWCP [Hicks]*, 138 F.3d 524 (4th Cir. 1998). As the medical evidence does not support a finding of a totally disabling respiratory impairment, these letters cannot support a finding of total disability.

Weighing the pulmonary function study evidence, the arterial blood gas study evidence, and the physician opinion evidence together, I find that Claimant has not established that he is totally disabled from performing his usual coal mine work. In addition, because Claimant has not established that he is totally disabled, he cannot establish disability causation.

## Conclusion

As Claimant failed to establish all of the requisite elements of entitlement, I find that he is not entitled to benefits under the Act.

## ORDER

The claim of Joseph A. Agnitsch for black lung benefits under the Act is hereby denied.

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STEPHEN L. PURCELL
Administrative Law Judge

**NOTICE OF APPEAL RIGHTS.** Pursuant to 20 C.F.R. Section 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date this Decision and Order was filed in the Office of the District Director, by filing a notice of appeal with the *Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601*. A copy of a notice of appeal must also be served on Allen Feldman, Esq., Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.